DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4132-FN]

Medicare and Medicaid Programs; Renewal of Deeming Authority of the Accreditation Association for National Committee for Quality Assurance (NCQA)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to renew the Medicare Advantage "deeming authority" of the National Committee for Quality Assurance (NCQA) for a period of 6 years. This new term of approval would begin October 19, 2014 and end October 18, 2020.

DATES: This final notice is effective October 19, 2014 through October 18, 2020.

FOR FURTHER INFORMATION CONTACT: Jennifer Bates, 410-786-6258 or Milonda Mitchell, 410-786-1644

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a Medicare Advantage (MA) organization that contracts with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met for a Medicare Advantage Organization (MAO) to enter into a contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to offer an MA contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of

services by Medicare-certified providers and suppliers. Under §422.400, one significant prerequisite for an entity to be an MA organization is that the organization be licensed by the state as a risk bearing organization, unless a waiver is authorized for a provider-sponsored organization pursuant to §422.370. In addition, MAOs and MA plans must meet requirements related to access to services, antidiscrimination, confidentiality and accuracy of beneficiary records, provider participation, advance directives, and quality assurance programs.

As a method of assuring compliance with certain Medicare requirements, an MA organization may choose to become accredited by a CMS approved accrediting organization (AO). In addition to their CMS-recognized deemed status accreditation program, approved AOs offer other accreditation programs that are not recognized by CMS. For Medicare participation purposes, the MA organization may be "deemed" compliant in one or more of six requirements set forth in section 1852(e)(4)(B) of the Act and §422.156(b). For an AO to be able to "deem" an MA plan as compliant with these MA requirements, the AO must demonstrate that it meets the requirements outlined in §422.157, including demonstrating that its standards are at least as stringent as Medicare requirements with respect to the standards in the deemable area. Therefore, for example, MA organizations that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and are accredited by an approved accrediting organization may receive, at the MA organization's request, deemed status for CMS requirements in the following six MA areas: Quality Improvement, Antidiscrimination, Access to Services, Confidentiality and Accuracy of Enrollee Records, Information on Advanced Directives, and Provider Participation Rules. (See §422.156(b).) Organizations that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As specified at §422.157(b)(2)(ii), the term for which an AO may be

approved by CMS may not exceed 6 years. For continuing approval, the AO must renew its application with CMS.

The National Committee for Quality Assurance (NCQA) was approved as an accrediting organization for MA deeming of HMOs on October 19, 2010, and that term will expire on October 18, 2014. On January 30, 2014, NCQA submitted an application to renew its deeming authority. On that same date, NCQA submitted materials requested from CMS which included updates and/or changes to items listed in §422.158(a) that are prerequisites for receiving deeming program approval by CMS, and which were furnished to CMS by NCQA as a part of its renewal applications for HMOs and PPOs.

II. Deeming Applications Approval Process

Section 1852(e)(4)(c) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days after the date of receipt of an application to complete our survey activities and application review process. In accordance with our policy for providers and suppliers, within 60 days of receiving a completed application, we must publish a notice in the **Federal Register** that identifies the national accreditation body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish an approval or denial of the application.

III. Proposed Notice

In the March 25, 2014, **Federal Register** (79 FR 16338), we published a proposed notice announcing NCQA's request for continued CMS approval of its deeming authority for MA HMOs and PPOs. In the proposed notice, we detailed our evaluation criteria. Under section 1852(e)(4) of the Act and our regulations at §422.158 (Federal review of accrediting

organizations), we conducted a review of NCQA's application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- The types of MA plans that it would review as part of its accreditation process.
- A detailed comparison of the AO's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).
- Detailed information about the organization's survey process, including the following—

++ Frequency of surveys and whether surveys are announced or unannounced.

++ Copies of survey forms, and guidelines and instructions to surveyors.

++ Descriptions of—

— The survey review process and the accreditation status decision making process;

— The procedures used to notify accredited MA organizations of deficiencies and to monitor the correction of those deficiencies; and

— The procedures used to enforce compliance with accreditation requirements.

- Detailed information about the individuals who perform surveys for the accreditation organization, including the following—

++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

++ The education and experience requirements surveyors must meet;

++ The content and frequency of the in-service training provided to survey personnel;

++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

++ The organization's policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.

- A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

- A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

- A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

- A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the accreditation organization.

- A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.

- A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization.

- The name and address of each person with an ownership or control interest in the accreditation organization.

• CMS's analysis of NCQA's past performance in the deeming program and the results of recent deeming validation reviews, or look-behind audits conducted as part of continuing federal oversight of the deeming program under §422.157(d).

In accordance with section 1865(a)(3)(A) of the Act, the March 25, 2014 proposed notice (79 FR 16338) also solicited public comments regarding whether NCQA's requirements met or exceeded the Medicare conditions of participation as an accrediting organization for MA HMOs and PPOs. We received no public comments in response to our proposed notice.

IV. Provisions of the Final Notice

A. Differences Between NCQA's Standards and Requirements for Accreditation and Medicare's Conditions and Survey Requirements

We compared the standards and survey process contained in NCQA's application with the Medicare conditions for accreditation. Our review and evaluation of NCQA's application for continued CMS-approval were conducted as described in section III of this final notice, and yielded the following:

• To meet the requirements at §422.158(a)(1), NCQA provided CMS with documentation listing its types of MA plans that it would review as part of its accreditation process. In addition, AO provided clarification and documentation to demonstrate how it distinguishes its CMS-recognized deemed status accreditation program from its other accreditation programs that are not recognized by CMS.

• AO revised its "Grounds of Revocation" policy to meet the requirements at §422.158(a)(3)(iii)(C) by revising its requirements to include non-compliance with "State, Federal, or other duly authorized regulatory or judicial action restricts or limits the organization's operations."

- To comply with the requirements at §422.158(a)(6), AO revised its processes for responding to and investigating complaints against accredited organizations by requiring the reporting of any serious problems identified with an MA plan to the designated CMS MA deeming representative.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that NCQA's accreditation program requirements continue to meet or exceed our requirements. Therefore, we renew NCQA as a national accreditation organization with deeming authority for MA HMOs and PPOs, effective October 19, 2014 through October 18, 2020.

V. Collection of Information Requirements

This document does not impose any new or revised information collection or recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

Dated: August 15, 2014

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Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

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